

National Health Care Reform: The Keys to Maintaining Grandfathered Status (If Desired) and Upcoming Notice Obligations

The following is the latest in a series of Patterson Belknap Alerts regarding the implications of the recently enacted health care reform under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (referred to collectively here as "PPACA") for employers. Prior Alerts can be found at <http://www.pbwt.com/resources/publications/navigating-health-care-reform/> and <http://www.pbwt.com/resources/publications/health-care-reform-guidance/>.

This Alert describes recent guidance regarding the types of changes to a group health plan which will cause the plan to lose its "grandfathered" status, and thus subject the plan to certain PPACA requirements from which grandfathered plans are exempt. In addition, this Alert describes employer/group health plan notification obligations which are effective prior to 2012.

A. Impact of Plan Changes on Grandfathered Status

As described in a prior Alert, "grandfathered" group health plans are not subject to certain PPACA provisions. The following chart briefly identifies whether grandfathered plans are subject to the following PPACA provisions:

Provision	Applicable to Grandfathered Plan?
Ban on Annual/ Lifetime Limits	Yes
Ban on Pre-Existing Condition Exclusions	Yes
Extended Coverage of Adult Children	Yes
Ban on Discriminating in Favor of Highly Compensated Individuals	No
Appeals Process Standards	No
Ban on Over the Counter Medication Reimbursement	Yes
Automatic Enrollment of Full-Time Employees by Large Employers	Yes
Advance Notice of Material Modifications	Yes
Penalties for Encouraging Employee Disenrollment	Yes
Premium Rebates for Plans with Low Medical-Loss Ratios	Yes
Temporary Reinsurance Program for Early Retirees	Yes
Ban on Cost-Sharing Requirements for Certain Preventative Health Services	No
Ban on Prior Authorization Requirements for Emergency Services	No
Limits on Ability to Rescind Coverage	Yes
Cost-Sharing Obligations for Out-of-Network Emergency Services	No
Participant Choice of Primary Care Physician/Pediatrician/Gynecologist	No
W-2 Health Coverage Cost Reporting Obligation	Yes

The Department of Labor has also posted a chart which highlights certain PPACA provisions, and the impact of grandfathering. That chart can be found at <http://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf>.

Under PPACA, a grandfathered plan generally is any group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010. But certain changes to that coverage can cause a loss of that grandfathered status. The Internal Revenue Service and Departments of Labor and Health and Human Services have jointly issued interim final regulations (the "Regulations") which identify the types of changes that will cause such a loss of grandfathered status.

We note that the Regulations include special rules regarding the maintenance of grandfathered status with respect to collectively bargained health plans. A description of those rules is beyond the scope of this Alert.

Changes Causing a Plan to Lose Grandfathered Status

The Regulations provide that if any of the following changes are made to a group health plan, the plan will lose its grandfathered status:

1. if an employer enters into a new policy, certificate or contract of insurance after March 23, 2010, then that new policy, certificate or contract of insurance is not a grandfathered plan with respect to individuals in the group health plan. Accordingly, the Regulations appear to indicate that if an employer changes insurers insuring an insured arrangement, the new arrangement will not be grandfathered, even if the terms of the coverage are the same as those provided with a prior insurer. However, we note that the Department of Labor recently indicated that it is considering guidance that may provide for certain circumstances under which grandfathered group health plans may change carriers without losing grandfathered status. However, that guidance has not yet been issued;
2. the elimination of all or substantially all plan benefits to diagnose or treat a particular condition, including the elimination of benefits for any necessary element to diagnose or treat a condition. For example, if a plan provides prescription and counseling benefits to treat a mental health condition, and the plan subsequently eliminates coverage for counseling, the plan will be considered to have eliminated all or substantially all of the benefits for that mental health condition;
3. *any* increase, measured from March 23, 2010, in a percentage cost-sharing requirement. For example, if a plan increases, from to 20% to 21%, the percentage of co-insurance a participant must pay for out-of-network coverage, the plan will lose its grandfathered status;
4. an increase to fixed amount cost-sharing requirements, other than co-payments, that is greater than medical inflation¹ plus 15 percentage points. Examples of fixed cost-sharing requirements include out-of-pocket limits and deductibles. Whether a plan has increased its cost-sharing requirement above this threshold is measured based on the cost-sharing requirements in place on March 23, 2010. Accordingly, while one increase may not trigger a loss of grandfathered status, a small subsequent increase may do so;

¹ For these and other purposes, "medical inflation" means the percentage increase in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (using the 1982-1984 base of 100), when compared to that CPI element for March, 2010. It is anticipated that the government will publish medical inflation statistics for purposes of grandfathering calculations.

5. an increase to fixed-amount co-payments, compared to March 23, 2010 levels, exceeding the greater of (a) five dollars increased by medical inflation (i.e., \$5 multiplied by medical inflation, plus \$5) or (b) medical inflation (when compared to March 23, 2010 levels) plus 15 percentage points. Whether a plan has increased its co-payment requirement above this threshold is measured based on the co-payment requirements in place on March 23, 2010;
6. if an employer decreases its contribution *rate* towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below its contribution rate in effect on March 23, 2010. An employer's contribution rate is calculated as a percentage based on a fraction, the numerator of which is the amount of contributions the employer makes, and the denominator is the total cost of coverage. The total cost of coverage is determined in the same manner as the COBRA premium.² With respect to self-insured plans, the employer contribution rate is determined by subtracting employee contributions from the total cost of coverage; or
7. if a group health plan imposes or modifies annual limits in any of the following manners: (a) the plan imposes a new overall annual limit on the dollar value of benefits, when the plan had not imposed any overall annual or lifetime limit on the dollar value of all benefits on March 23, 2010; (b) the plan adopts an overall annual limit on the dollar value of benefits that is lower than a lifetime limit, when, as of March 23, 2010, the plan imposed an overall lifetime limit on the dollar value of benefits but had not imposed an overall annual limit; or (c) the plan imposed an overall annual limit on the dollar value of all benefits on March 23, 2010 and subsequently lowers that annual limit.³

Changes That Will Not Cause a Group Health Plan to Lose Grandfathered Status

Only the changes identified in the Regulations will cause a plan to lose its grandfathered status. A group health plan that makes changes to comply with PPACA will not lose its grandfathered status because of those changes. In addition, the following changes will *not* cause a plan to lose its grandfathered status: (a) an employee who was not previously enrolled in the plan deciding to enroll in the plan; or (b) an employee's family member deciding to enroll in the plan. However, the Regulations include an anti-abuse provision, which provides that if the principal purpose of a merger, acquisition or similar business restructuring is to cover new individuals in a grandfathered health plan, the plan will lose its grandfathered status.

² Because penalties can be imposed on a health insurance issuer that doesn't provide PPACA-required benefits, but an issuer may not know exactly how much is being paid by an employer, rather than by employees, for coverage (and thus whether a plan has lost its grandfathered status because of a change in the employer contribution rate), the Department of Labor has indicated that, until the issuance of final regulations, an insured group health plan will not be treated as having lost its grandfathered status based on a change in the employer contribution rate, provided the plan has not otherwise lost grandfather status because of another change listed in this Alert and if the issuer does not actually know that the plan sponsor has decreased its contribution rate below the threshold identified above. That special treatment is only available, however, if: (a) the issuer requires a plan sponsor to make a representation regarding the contribution rate for the plan year covered by the renewal and the contribution rate in effect on March 23, 2010; and (b) the issuer's policies, certificates or contracts of insurance disclose in a prominent manner that plan sponsors are required to notify the insurer if the contribution rate changes at any point during the year. With respect to policies renewed before January 1, 2011, issuers must take these steps by January 1, 2011.

³ Regardless, a group health plan continues to be subject to the PPACA prohibition on a group health plan's imposition of lifetime dollar limits on "essential benefits" and PPACA's restrictions on annual dollar limits on "essential benefits" included in group health plans in effect prior to plan year years beginning prior to January 1, 2014. PPACA prohibits group health plans from imposing any annual dollar limits on "essential benefits," beginning with plan years beginning on or after January 1, 2014.

The Department of Labor has also indicated in informal guidance that the following changes would generally not cause a plan to lose grandfathered status (so long as any of these changes do not also constitute a change listed in items 1 through 7 above): changes to premiums, changes to provider networks, changes to third party administrators and changes to prescription drug formularies. The Department has noted, however, that if, in making a change to a prescription drug formulary, the change results in the elimination of all (or substantially all) of the benefits for treating a condition, the plan would lose its grandfathered status. For example, if a change to a prescription drug formulary eliminates coverage for all medications used to treat depression, the plan would lose grandfathered status. The Department has also indicated that if an employer eliminates coverage for a class of employees and/or family coverage, its plan should not lose grandfathered status. Changes to comply with Federal or State Law or to voluntarily comply with PPACA, according to the Department of Labor, also should not cause a plan to lose grandfathered status.

Transition Rules

A plan will not lose its grandfathered status as a result of changes which are effective after March 23, 2010 under the following circumstances: (a) the changes are pursuant to a legally binding contract entered into on or before March 23, 2010; (b) the changes are pursuant to a filing on or before March 23, 2010 with a State insurance department; or (c) the changes are pursuant to written plan amendments that were adopted on or before March 23, 2010.

The Regulations include a grace period to allow group health plans to revoke or modify any changes adopted prior to June 14, 2010, if those changes would otherwise cause the plan to cease to be a grandfathered health plan. Grandfathered status could be preserved so long as the changes are revoked or modified, effective as of the first day of the plan year beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar year plans), and the terms of the plan, as modified, would not cause the plan to cease to be a grandfathered plan.

Benefit Package by Benefit Package Assessment

The rules for maintaining grandfathered plan status apply separately with respect to each "benefit package" offered under a group health plan. Thus, if a group health plan offered two benefit packages, such an HMO package and a PPO package, making changes to one package (such that the package loses grandfathered status) would not mean that the second package would automatically lose grandfathered status also. However, if a plan offers two benefit packages and eliminates one benefit package so that the participants in the eliminated package are transferred into the remaining package, the remaining package generally will lose its grandfathered status.⁴

Disclosure of Grandfathered Status: Required Notice to Participants

To maintain grandfathered status, a group health plan must provide a statement that the plan believes it is a grandfathered health plan under PPACA, and the statement must include contact information for

⁴ The remaining benefit package will lose its grandfathered status, unless there is a bona fide employment-based reason to transfer the employees to the remaining benefit package (and changing the terms or cost of coverage does not constitute a bona fide employment-based reason), if the terms of the eliminated benefit package are so different from the terms of the remaining benefits package, such that if the eliminated benefit package had, instead of being eliminated, been amended to reflect the terms of the remaining benefit package, those changes would have resulted in the eliminated benefit package losing its grandfathered status.

questions and complaints. The Regulations include model statement language, which can be found at <http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc>. The statement should be included in any plan materials provided to participants and beneficiaries which describe benefits under the group health plan.

Maintenance of Records

To maintain grandfathered status, a group health plan must retain records documenting the terms of the plan in effect on March 23, 2010, and any other documents necessary to verify, explain or clarify the plan's status as a grandfathered plan. Examples of those documents include: plan documents (such as a summary plan description), health insurance policies, certificates of insurance, documentation of premiums or the cost of coverage and documentation of required employee contribution rates. These documents must be available for inspection and must be retained for so long as the group health plan takes the position that it is a grandfathered plan.

B. Notice Requirements

PPACA has specifically imposed certain new notice obligations on group health plans. The following section highlights significant notices which are required, or are otherwise advisable, to be provided in the near future:

1. Notice Regarding New Rules Limiting Reimbursement for Over-the-Counter Medications.

As described in our prior Alert (which can be found at <http://www.pbwt.com/resources/publications/navigating-health-care-reform/>), effective for expenses incurred beginning in 2011, health flexible spending arrangements, health savings accounts, health reimbursement arrangements and Archer MSAs (including grandfathered plans) may not reimburse participants for the cost of medication unless the medication is a prescribed drug or insulin, and thus may not reimburse costs of most over-the-counter medications. Because some of these plans may be subject to PPACA advance notice of material modification requirement (discussed below), we recommend that employers notify employees of this change by November 1, 2010, so that employees can properly plan their expenditures. Early notification is particularly important as an individual cannot be reimbursed from his or her flexible spending account for over-the-counter medications purchased after 2010, even during a 2011 grace period that relates to elections for the 2010 calendar year plan.

2. Advance Notice of Material Modification to Group Health Plan.

PPACA generally requires a group health plan (including a grandfathered plan) to provide advance notice of a material plan modification at least 60 days prior to the effective date of the change. This is a change to the prior ERISA requirement, which does not require that notice of health plan changes be delivered in advance of such changes. PPACA provides that this requirement is effective for grandfathered plans for plan years beginning on or after the March 23, 2010 enactment date, and is effective for new plans for plan years beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar year plans).⁵

⁵ As discussed in our prior Alert, it is not entirely clear when a plan must begin complying with this notice obligation. PPACA provides that a notice of changes must only be provided if the change is not reflected in the most recently provided summary of benefits and coverage required under PPACA. But because a group health plan has until March 23, 2012 to start providing the PPACA-required summary (and guidance must be issued as to the required content of such summary), it is not entirely clear whether a plan must provide an advance notice of changes before the PPACA-required summary is required to be provided. In the absence of further guidance regarding the effective date of the advance notice of change requirement, however, we recommend that plans give advance notice of material changes in accordance with the schedule identified above for new plans or grandfathered plans, as applicable.

3. **Notice of Special Enrollment Period for Adult Children.** As described in a prior Alert (which can be found at <http://www.pbwt.com/resources/publications/health-care-reform-guidance/>), employers must provide an employee's adult children, who are eligible to enroll in an employer's group health plan (including a grandfathered plan) under PPACA's rule regarding coverage for adult children until age 26, with a special enrollment period that continues for at least 30 days after the extension option first becomes available (generally required no later than the first day of the first plan year after September 23, 2010 (i.e., January 1, 2011 for calendar year plans)). Employers must provide a written notification of this special enrollment period, which may be provided to the parent employee on behalf of the eligible adult child. Notice of the enrollment period may be included in the plan's regular enrollment materials, provided that the notice is "prominently" noted in the materials. The IRS and the Departments of Labor and Health and Human Services have jointly issued model language which can be used to satisfy this obligation, which can be found at <http://www.dol.gov/ebsa/dependentsmodelnotice.doc>.
4. **Notice of Special Enrollment Opportunity with Respect to Individuals Previously Excluded from Coverage Because of a Lifetime Limit.** PPACA generally prohibits a group health plan (including a grandfathered plan) from imposing annual and lifetime limits on the dollar value of "essential" benefits available to plan participants and beneficiaries. If an individual had been excluded from group health plan coverage because the individual had reached a lifetime limit, and thus previously lost his or her coverage, the plan and issuer are required to give the individual written notice that the lifetime limit no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. In addition, if the individual is not enrolled in the plan, then the plan and issuer must give the individual written notice of a special opportunity to enroll. The IRS and Departments of Labor and Health and Human Services have jointly circulated model language that can be used to satisfy the notice requirements. The language can be found at <http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc>. The notices must be provided not later than the first day of the first plan year beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar year plans), and may be included with other enrollment materials so long as the statement is "prominent." The interim final regulations provide that a plan may provide the notices to an employee on behalf of the employee's dependent.
5. **Grandfathered Plan Status.** As described above, to maintain grandfathered status a group health plan must provide a statement that the plan believes that it is a grandfathered health plan. The Regulations include model statement language, which can be found at <http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc>. The statement should be included in any plan materials provided to participants and beneficiaries which describe benefits under the group health plan.
6. **Claims and Appeals Notices.** Interim final regulations issued with respect to PPACA's claims and appeals process impose certain requirements on non-grandfathered plans with respect communications regarding adverse benefit claims determinations, which are in addition to the current ERISA requirements for adverse benefit determination communications. The IRS and Departments of Labor and Health and Human Services have jointly issued model notices with respect to an adverse benefit determination and final internal adverse benefit determination. These notices can be found at <http://www.dol.gov/ebsa/IABDModelNotice2.doc> and <http://www.dol.gov/ebsa/IABDModelNotice1.doc>.
7. **Notice of Right to Designate a Primary Care Provider and to Use an Obstetrician or Gynecologist.** If a group health plan (other than a grandfathered plan) requires a participant or beneficiary to designate a primary care physician, the plan or issuer must provide a notice

informing each participant of the terms of the plan regarding PPACA's rules with respect to designating a primary care physician (including a pediatrician). Similarly, a group health plan or issuer must notify each participant that the plan may not require authorization or referral for obstetrical or gynecological care provided by an obstetrician or gynecologist. The notice must be included when a plan provides a participant with a summary plan description or other similar description of benefits. The IRS and Departments have jointly issued model language which can be used to satisfy this obligation. The model language can be found at <http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc>.

8. **Notice of Rescission of Coverage.** Under PPACA, a group health plan (including a grandfathered plan) may rescind coverage only under limited circumstances (such as in the case of fraud or an intentional misrepresentation of fact), beginning with plan years starting on or after September 23, 2010. A rescission is a cancellation or discontinuance of coverage that has retroactive effect (unless the cancellation is effective retroactively to the extent it is due to a failure to timely pay premiums). Interim final regulations provide that a group health plan, or a health insurance issuer offering group health insurance coverage, must provide at least 30 calendar days' advance notice to an individual before coverage may be rescinded.
9. **Early Retiree Reinsurance Program Participant Notice.** Sponsors participating in the Early Retiree Reinsurance Program ("ERRP") (as described in prior Patterson Belknap Alerts at <http://www.pbwt.com/resources/publications/navigating-health-care-reform/> and <http://www.pbwt.com/resources/publications/health-care-reform-guidance/>) must provide all plan participants with a form notice, informing them that because the sponsor is participating in the ERRP with respect to the plan, the sponsor may choose to use the reimbursements to reduce plan participants' premium contributions, copayments, deductibles, co-insurance, or other out-of-pocket costs, and therefore plan participants may experience such changes in the terms and conditions of their plan participation. This notice must be delivered within a reasonable time after the sponsor receives its first ERRP reimbursement, and may even be delivered before the first ERRP reimbursement is received. The Department of Health and Human Services has advised that the notice may be included with other plan materials provided to plan participants and may be delivered by an entity contracted by the sponsor (although it is the sponsor's obligation to ensure that the notice is properly delivered). Although the form notice must be provided to all plan participants (including enrolled spouses, surviving spouses, and dependents), only one notice need be sent if it is addressed to all participants who are family members. The Department of Health and Human Services has issued a form notice which sponsors must use. The form notice can be found at http://www.errp.gov/download/Notice_to_PlanParticipants.pdf. ♦

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